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February 21, 2013

Honorable Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: CMS-2334-P; Comments to Notice of Proposed Rulemaking on Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing

Dear Secretary Sebelius:

On behalf of the State of California and two of the entities responsible for implementing the Patient Protection and Affordable Care Act in the state—the Department of Health Care Services and Covered California, our state's Health Benefit Exchange—we submit the enclosed comments on the proposed rules for Medicaid, Children's Health Insurance Program (CHIP), and Exchanges. California appreciates the opportunity to comment on these critically important regulations.

California appreciates the significant effort involved in establishing the standards relating to appeals processes, combined notices, and termination of coverage. However, it is critical that, to the extent possible, the final rules provide states the ability to phase-in the components of the rules that require significant development, such as the electronic appeals interface and the combined notice requirements.

The comments below highlight key issues identified by California Department of Health Care Services and Covered California in the proposed rule. In the attached comments, which are presented in both narrative and chart format, the departments offer input into needed clarity/flexibility of the proposed rules.

1. **Alignment with Exchange initial open enrollment period**: Given the short time frame for developing new information technology systems, accompanying business rules, and required interfaces to existing systems, California may need to rely on existing eligibility systems and program applications in the period between October and December 2013. To address this issue, California strongly recommends that states have the option to propose an alternative eligibility determination approach for individuals seeking coverage in MAGI-based Insurance Affordability Programs (IAPs) during the initial open enrollment period.

2. **Electronic appeals interface:** California supports the goal of electronic data exchange for eligibility appeals that impact multiple IAPs. However, the state of automation of appeals processes is not sufficiently developed at this time to accommodate electronic interfaces. The federal government has acknowledged in its requirements for combined notices that it is not feasible to implement that process by October 1, 2013. The situation is comparable for data exchanges that are part of the appeals process. California therefore recommends that states be able a phased-in approach to establishing a secure electronic interface between the Exchange and other IAPs.

3. **Combined notices:** California appreciates the value of issuing combined eligibility notices whenever possible to minimize confusion and increase clarity for consumers. However, California notes that combined notices will take considerable time and stakeholder engagement to develop. We support a phase-in of combined notices beginning on January 1, 2015.

Exchange-specific highlights – please direct any questions regarding these comments to Covered California

4. **Verify employer minimum essential coverage (MEC) and manage employer MEC appeals:** California is actively considering using the federal options to verify employer MEC and conduct appeals due to the fact that California does not currently have a data source to verify this information. California appreciates the availability of the federal option until workable state and federal data sources can be developed.

5. **Informal resolution process for Exchange appeals:** California supports the concept of informal resolution which, as HHS notes in the preamble, could effectively resolve issues for consumers and obviate the need for a fair hearing. California notes, however, that the 90-day appeal period does not provide sufficient time to conduct a comprehensive informal process while ensuring the appellant's right to a formal hearing. For this reason, California recommends that states be given a total of 120 days from the date of the appeal request, rather than 90 days, to issue the final formal decision.

Medicaid-specific highlights – please direct any questions regarding these comments to the Department of Health Care Services

6. **Enhanced Medicaid funding for financing health care reform:** California appreciates the commitment made to provide enhanced federal funding for the newly eligible populations that are at the option of the state to cover. California has worked to create a sustainable budget environment and will implement the Affordable Care Act in a similar manner. Maximizing 100 percent federal funding, to the extent there is an increase in eligibility and/or benefits resulting from a federal requirement, is important to achieving and maintaining this sustainable budget environment.

7. **Alternative benefit plans:** The Department requests that no supplementation be required if state plan benefits are selected for the new adult group under the secretary-approved option. If retained, we request a more simplified and flexible process for evaluating Essential Health Benefit (EHB) compliance in Medicaid.

8. **Alternative Benefit Plans and Long Term Care:** The Department requests the flexibility to exclude non-EHB services such as long term care from the new adult group benefit package.

9. **Mental health and substance use disorder parity:** The Department requests formal guidance clarifying the legitimacy of the continued use of carve-out arrangements for delivery of these benefits.

10. **Medically needy populations:** The Department requests further guidance on the ability to cease enrollment of parent/caretaker relatives and applicable pregnant women into this coverage group and move them to Exchange coverage when they have spend down/share of cost.

11. **Family planning state plan option and MAGI:** The Department requests that MAGI is not applied when the Affordable Care Act family planning “grandfathering” clause was exercised in conversion of a waiver to the state plan.

12. **Hospitals and presumptive eligibility:** The Department requests sufficient flexibility and federal support for enforcement policies aiming to safeguard program integrity.

13. **Cost sharing:** The Department requests that the regulation allow for more state authority to enforce permitted cost sharing policies.

Thank you for taking these comments into consideration as you finalize the rules and as California approaches the full implementation of the Patient Protection and Affordable Care Act, which the departments have all worked diligently to successfully implement.

Sincerely,

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Peter V. Lee
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Covered California

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Appeals	***42 CFR:*** **431.10** **431.200** **431.201** **431.205** **431.206** **431.211** **431.213** **431.220** **431.221** **431.224** **431.230** **431.231** **431.232** **431.240** **431.241** **431.242** **431.244** **435.4** **435.907** **435.1200** ***45 CFR:*** **155.302**	• 431.10 (c)(1)(ii)– If the Exchange conducts hearings for denials of eligibility based on the applicable MAGI standard for the Medicaid agency, then the individual requesting a hearing on a denial needs to be given the choice to have a hearing conducted by the Medicaid agency (or Exchange or Exchange appeals entity). • In addition, if Medicaid delegates fair hearings to the Exchange, only denials of eligibility based on MAGI are addressed, rather than "all Federal and State law, regulations and policies, including but not limited to, those related to the eligibility criteria applied by the agency…" and the Medicaid agency may have a process to review all hearings decisions issued by the Exchange(c)(3)(iii). • The regulation also appears to be contradictory. The regulation provides that 431.10(c)(3) that "the Medicaid agency: (i) Must ensure that any agency or public authority to which eligibility determinations or appeals decisions are delegated (A) complies with all relevant Federal and state law, regulations and policies, including, but not limited to, those related to the eligibility criteria applied by the agency under part 435 of this chapter…" This language could encompass the delegation of all eligibility denials to the Exchange but the language of section 431.10(c)(1)(B)(2) is not expansive enough to include the delegation of all appeals to the Exchange. • Finally, in regard to the request for comment on the following statement: "Medicaid agencies may delegate authority to conduct fair hearings to a State-Based Exchange that is also a state agency either under the proposed regulations or by requesting a waiver under the Intergovernmental Cooperation Act of 1968. The primary difference would be that, under the waiver approach, the state would not be required to provide individuals with the option to have the Medicaid agency conduct their fair hearing. We seek comments on whether Medicaid agencies should have authority under the regulations to delegate fair hearing authority to any state agency, subject to the same limitations as those proposed for delegations to a state based Exchange." • 431.10(d)(2) requires quality control and oversight by Medicaid agency at additional expense for two hearing processes (Exchange and Medicaid). • 431.221 – Permits individuals, or an authorized representative, to request hearings via commonly available electronic means and via the internet website. This expands avenues for submitting hearing requests and fails to take into account such social media, such as Facebook, Twitter, etc., which could reasonably be included in any definition of "commonly available electronic means." • 431.224 – Requires an expedited review process for individuals (includes requests made by providers or requests by providers that support the individual's request) whose health does not permit waiting for a	• States should have the authority under the regulations to delegate fair hearing authority to any state agency including those currently used without having to duplicate any of the current appeals processes. • Given the desire to capitalize on use of electronic means of data transmission, consideration and flexibility should be given to states in terms of implementation and timeframes to have such processes in place and clarification should be provided on these provisions. Consideration should be given to all of the efforts states must undertake to be ready for 2014 in terms of the eligibility determinations and enrollment simplifications and system builds. • To the extent systems need to be developed to effectuate these requirements, federal funding should be available and at enhanced rates since such efforts are intrinsically linked to simplified eligibility processes as required under ACA. • Clarification is needed on whether or not an expedited hearing is appropriate to occur within 2 days of the request [431.224(b)(2)] or rendering a decision within the 3 day requirements in 431.244(f)(3) based on the individuals health condition. These time periods should be explicit and each should have its own time period or the beneficiary's request for an expedited hearing will be the

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		regularly scheduled hearing. Specifically, the time delay for a hearing could jeopardize the individual's life or health or ability to attain, maintain, or regain maximum function. • 431.231 – Requests for aid paid pending must be within 10 days of receipt of the notice of action. The proposal defines the receipt of the notice to be 5 days from the date on the notice, unless the beneficiary shows that he/she did not receive the notice within the 5-day period. • 431.232 – Adds 5 days to the date on the notice of action to determine the date of receipt of the adverse decision of the local evidentiary hearing and must request an appeal to the State agency within 10 days after the individual receives the notice of the adverse decision. • 431.241 – Share of cost and cost-sharing clearly added as issues appropriate for appeal. • 431.244(f)(3) – Provides for hearing decisions within 45 days or on an expedited basis based on an individuals health condition but no later than 3 work days.	same as the expedited hearing decision. There may not be enough time to hold the expedited hearing based upon the client's condition but no later than 3 days from the request. Further, the following needs to be addressed: o Will there be an intermediate level of review of the expedited hearing request? o Will the individual be required to submit the necessary records as part of the expedited hearing request? o Given the modes by which a hearing can be requested, will appeals staff have to be available on an "on-call" basis? • Given the proposal to request hearings via commonly available electronic means and via the internet website, this expands avenues for submitting hearing requests and fails to take into account such social media, such as Facebook, Twitter, etc. These other commonly available social media could reasonably be included in any definition of "commonly available electronic means" thus clarification and/or a definition is needed for "commonly available electronic means."
Notices	***42 CFR:*** **435.917 435.918 435.1200** ***45 CFR*:**	• To the maximum extent feasible, state Medicaid and CHIP agencies and the Exchange produce a single combined notice after all MAGI-based eligibility determinations have been made. • Given the time needed to allow for systems builds, we are proposing that the policy to provide a combined eligibility notice will not be effective until January 1, 2015. At state option, based on the operational readiness of all programs, combined eligibility notices may be implemented earlier. • 435.918(a)(1) requires confirmation of the individual's election to receive electronic notices be made by	• California concurs with giving additional time to states to implement the combined eligibility notices. California strongly supports a phased-in approach, where IAP agencies focus on coordinated eligibility notices until January 1, 2015. We

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	155.345(a)(3)	regular mail. • CMS is soliciting comments on the level of detail which should be required for inclusion in the notice under §435.917(c). • 435.917(c) - Whenever eligibility is denied or terminated based upon income in excess of the applicable MAGI income standard, the notice must contain information regarding eligibility on other bases and respective benefits and services and how to request a full eligibility determination. • 435.1200(a)(1) states: "This section implements sections 1943(b)(3) and 2201(b)(3)(B) of the Affordable Care Act to ensure coordinated eligibility and enrollment among insurance affordability programs." There is no section 1943 of the ACA. There is, however, a section 1943 of the Social Security Act. In addition, there is no section 2201(b)(3)(B) of the ACA. Section 2201 of the ACA does not have a "(b)(3)(B)".	recommend that combined eligibility notices be phased-in beginning on January 1, 2015. • Unclear as to the need to confirm requests for electronic notification via regular mail. There are ways to confirm an individual's request via the online portals without being required to resort to regular mail. • Beyond what is required in regulation, states should be given flexibility in terms of additional information that will be contained in the applicable notice and the format in which such information can be provided, such as in a brochure format.
Authorized Representative (AR)	***42 CFR:*** **435.923** ***45 CFR*:** **155.227**	• Applicants and beneficiaries may choose to designate an individual or organization to act on the applicant or beneficiary's behalf. • CMS notes, before data can be released to an authorized representative, the representative must meet the authentication and data security standards of the releasing entity. For example, information relating to an applicant's modified adjusted gross income from the Internal Revenue Service cannot be requested by or released to an authorized representative unless the representative meets the authentication and security standards established by the IRS under section 6103 of the Code. • CMS intends that the single streamlined application described in §435.907(b)(1) of the regulations will provide applicants the opportunity to designate an authorized representative and will collect the information necessary for such representative to enter into any associated agreements with the agency as part of the application process. States developing alternative applications under §435.907(b)(2) must collect the same information through their alternative applications or supplemental forms. • The agency must accept electronic, including telephonically recorded, signatures authorizing representation as well as handwritten signatures transmitted by facsimile or other electronic transmission. Designations of authorized representatives under the proposed regulation must be accepted through all of the modalities described in §435.907(a). • 435.923(c) states that the appointment of AR is valid until the applicant or beneficiary modifies the authorization.	• For purposes of designating an AR, it is strongly recommend the specific designation of a person versus an organization. • While we are supportive of giving individuals choice in this arena, it is unclear how designating an "organization" can appropriately act in the best interest of the individual. To the extent an organization is the designated AR, it is unclear who within the organization can be ultimately responsible for acting on behalf of the individual. • By designating a person versus an organization, states are better able to ensure greater transparency and accountability of the AR to the individual.

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Presumptive eligibility (PE) for other individuals	**435.1103**	• CMS proposes, consistent with section 1920 of the Act and current policy, that a state may elect to provide presumptive eligibility for pregnant women in the same manner as described for children at the proposed §435.1101 and §435.1102, except that pregnant women are only covered for ambulatory prenatal care during a presumptive eligibility period. • CMS proposes that pregnant women are limited to one presumptive eligibility period per pregnancy. • If the state has elected to provide presumptive eligibility for children or pregnant women, the state may also elect to provide presumptive eligibility for the additional populations provided for in the Affordable Care Act – that is, -- parents and other caretaker relatives (described in §435.110, adults described in §435.119, and individuals under age 65 described in §435.218 of the Medicaid eligibility final rule, as well as former foster care children described in §435.150 of this proposed rulemaking. • CMS proposes at paragraph (c) that a state may cover presumptive eligibility for individuals needing treatment for breast or cervical cancer as described at proposed §435.213 of this rulemaking; and at paragraph (d) that a state may provide limited family planning benefits on a presumptive eligibility basis for individuals who may be eligible for such services under proposed §435.214 of this rulemaking.	• Section 435.1103 proposes limits on pregnant women in terms of PE periods but there are no similar limits on other adults such as parents/caretaker relatives and adults age 19-64. • For purposes of implementing the hospital PE provision, , flexibility should be given to allow states to impose similar limits i.e. 60 day timeframe, onto other adults such as parent/caretaker relatives and adults age 19-64 which would be specified in State Plan Amendments or 1115 waiver authority to further strengthen the PE policy. This will also aid in ensuring greater transparency and accountability for hospitals granting PE.
Medically Needy	**435.301** **435.310** **435.831**	• 435.310 Doesn't mention what happens to subsection (b) that addresses "specified relatives". In all other cases, "specified relatives" has been removed or changed to specify parents/caretaker relatives. • 435.831(b)(1) – revised to permit MAGI, however, States are still required to use the old financial responsibility of parent for child and spouse for spouse because of 42 CFR 435.602, financial responsibility of relatives and other individuals. Without being able to use the tax filing unit, we would have to undo the MAGI number that we got from the IRS and re-do everything for each household requiring the application of *Sneede/Gamma vs. Kizer*. • *Sneede vs. Kizer and Gamma vs. Belshe Background:* January 5, 1990, the U.S. District Court in the case of Sneede vs. Kizer, prohibited the Department from including the income and resources belonging to persons other than a spouse or natural/adoptive parent when determining Medi-Cal eligibility and share of cost for anyone applying for or receiving Medi-Cal benefits. November 16, 1995, the U.S. District Court in the case of Gamma vs. Belshe, concluded that current Sneede methodology should be changed to allow income to be allocated to first meet the parent's need standard.	• 435.310: o Please clarify if specified relatives should be removed or changed to specify parent/caretaker relatives o California proposes not to determine Medicaid AFDC/MN eligibility for individuals found eligible to receive APTCs, but whose application indicates potential eligibility for the non-MAGI AFDC/MN programs, unless such individual formally requests a full Medicaid eligibility determination, given the provision of proper notice at the time of application regarding the

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			availability of coverage on non-MAGI bases, the applicable coverage differences, and the ability to request a full Medicaid determination. o Requiring a non-MAGI AFDC/MN eligibility determination for individuals, without their express request for such a full Medicaid determination would impose a significant administrative burden on California and may cause confusion and a burden to individuals who were satisfied with their determination and award of APTCs. o California agrees that retaining the AFDC methodology for the purpose of determining income for medically needy coverage is burdensome for California and consumers. However, requiring states to develop MAGI based income and household composition and then ensure that there is no deeming of income or attribution of financial responsibility aside from spouse-to-spouse and parent-to-child might prove to be more complicated and burdensome than maintaining the current AFDC methodology. o CMS should consider allowing states to implement the MAGI method for the purpose of determining income for the medically needy program without considering financially responsibility of responsible relatives.
Coordinated	**435.1205**	• CMS is proposing a new §435.1205 to similarly provide that Medicaid and CHIP agencies begin	• Language at 435.1205(c)(3)(ii) should

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Medicaid/CHIP Open Enrollment Process		accepting the single streamlined application during the initial open enrollment period to ensure a coordinated transition to new coverage that will become available in Medicaid and through the Exchange in 2014. • CMS is proposing to permit Medi-Cal eligibility determinations during the Exchange open enrollment period with an effective date of January 1, 2014. • States have the option to set the annual renewal date to anytime between 12 months from the date of application and January 1, 2015. • During the open enrollment period, states may use the single streamlined application to determine Medi-Cal eligibility using the 2013 pre-ACA eligibility rules. Along with the single streamlined application, states may use supplemental forms to collect additional eligibility data. • States also have the option to notify the applicant of the opportunity to submit a separate application for coverage effective in 2013.	clarify that this state option authorizes less than annual periods of coverage/eligibility before renewal in instances where renewal date is set before 1/1/2015. • For this option, states should only notify those applicants who appear to be eligible for coverage effective in 2013 based on the single, streamlined application, in order to avoid administrative burden and beneficiary confusion.
Premium Assistance	**435.1015**	• Preamble page 4624: A state Medicaid or CHIP program could use existing premium assistance authority to purchase coverage for a Medicaid or CHIP-eligible individual through a QHP, while other family members would receive advance payment of the premium tax credit. However, APTC would not be provided for the Medicaid or CHIP-eligible family members. • Premium assistance could help increase the likelihood that individuals moving from Exchange coverage into Medicaid or CHIP may remain in the same QHP in which they had been enrolled through the Exchange. We invite comments on how the state Medicaid and CHIP agency can coordinate with the Exchange to establish and simplify premium assistance arrangements and how these arrangements will be operationalized. • The current Medicaid premium assistance program is likely to be rarely be utilized due to the requirement that premiums exceed documented cost and Non-Medicaid/CHIP individuals only qualify is they are part of a group policy used by a Medicaid/CHIP beneficiary. There will be some Exchange members that become Medicaid eligible and also meet the cost savings requirement but based on current experience with Medicaid insurance premium assistance programs, it is not anticipated that many will be eligible for this type of assistance.	• Clarification is needed as to whether or not a woman who is on APTCs via the Exchange and subsequently becomes pregnant (and her income was within the eligible limit for pregnant women under Medicaid), the extent to which Medicaid could pay her Exchange premiums so her coverage would remain with the Exchange versus having to move into a Medicaid delivery system.
Application of MAGI	**435.603**	• The preamble provides an example of applying this provision as it relates to parent/caretaker relatives vs. the new adult group. In reference to the children groups, it appears that the 5 percent disregard would be applied to eligibility under the children's group with the highest MAGI-based income standard, which for most states would be coverage under CHIP or coverage under the optional targeted low income program. If this interpretation is correct, California agrees because applying the 5% disregard	• For states electing to implement the optional Targeted Low Income Children's group under Section 1902(a)(10)(A)(ii)(XIV) of the Act and also implement cost-sharing provisions

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		to only the Medicaid children coverage groups would create a partially funded expansion mandate. • 435.603(4): In determining the eligibility of an individual for medical assistance under the eligibility group with the highest income standard under which an individual may be determined eligible using MAGI-based methodologies, an amount equivalent to 5 percentage points of the Federal poverty level for the applicable family size is deducted from household income.	in accordance with Section 1916 A of the Act for those targeted low income children with income above 150% of the FPL - will the 5% MAGI income disregard be applicable to only eligibility for the coverage group or would the 5% MAGI disregard also be applicable to cost-sharing provisions within the coverage group? • Given the Section 1902(e)(14)(A) requirement to establish MAGI income standards equivalent to levels used at ACA enactment, are states being required to expand their income levels for pregnant women and children by five percent due to application of the disregard? Or, may states account for application of the five percent disregard in establishing effective MAGI equivalents for these groups and remain in compliance with (e)(14)(A) and the MOE provisions?
Determination of Eligibility	**435.911**	• 435.911(b)(1) - Sets the minimum applicable MAGI income standard or minimum income floor of 133% of FPL or higher for parents/caretaker relatives, pregnant women and children. There is no conflict for pregnant women and children, but the 133% FPL minimum floor for parents and caretaker relatives is higher than the income limit described in 435.110(c) for parents/caretaker relatives. If the minimum applicable MAGI income standard for the parents/caretaker relative group is maintained at this higher level, then states attempts to move more parents/caretaker relatives into the VIII group will not be successful, although Section 435.110(c) would permit states to set their effective income thresholds back to a minimum of 1988 AFDC income standards. If, as in the case of pregnant women and children, this subsection referred back to the income standard set in 435.110(c), then states would be able to lower their effective income levels for parents and caretaker relatives to the 1988 AFDC income standards at the end of the maintenance of effort period and many more individuals would be eligible in the VIII group.	• This section appears to set a minimum applicable MAGI income standard floor of 133% FPL. For example, section 435.110 (c) establishes a minimum and maximum income standard for the parent/caretaker relative group which can be established once the MOE is no longer applicable for adults. • For states whose MAGI converted income standard in accordance with 435.110(c) falls below 133% FPL, it appears the minimum applicable

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		• 435.911(b)(2) Attempts to clarify that MAGI is applied to individuals over 65, or individuals at least 19 and entitled or enrolled in Medicare A or B, when that individual is also a pregnant woman or parent/caretaker relative. In other words, they are to be treated as a pregnant woman or parent/caretaker relatives first before being considered aged, blind or having a disability.	income standard of 133% FPL at section 435.911 would apply thus a state would not be able to apply the lower standard, such as might be the case if a state elected to apply the minimum converted AFDC income standard of May 1, 1988 as proposed in section 435.110 (c)(1) of this proposed rule. • Please clarify the relationship between 435.110(c) and 435.911 (b)(2). • The way that subsection (b)(2) is currently written, it would require the individual be BOTH over 19 and over the age of 65 and a parent/caretaker relative and a pregnant woman. To completely clarify this subsection, the "and" between individuals who are at least 65 and 19 needs to be changed to an "or" and the "and" at the end of subsection (b)(2)(i) needs to be changed to an "or". • Finally, given the identification of those individuals who are eligible on bases other than MAGI, disabled children should also be addressed. Children, although they are disabled, should first be placed in the MAGI children's group similarly to the disabled parents and caretaker relatives.
Premiums and Cost Sharing	**447.50** **447.51** **447.52** **447-53**	• Proposes revisions to simplify policies and harmonize rules between Sec. 1916 and 1916A of the Act • Updates maximum allowable amounts for nominal cost sharing • Proposes single rule for drug cost sharing • Proposes new rule for cost sharing imposed on non-emergency services furnished in ER	• Language at 447.53(d) should be aligned with preamble policy at 78 FR 4659 which applies the $8 maximum for non-preferred drug copayments for both

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	447.54 **447.55** **447.56** **447.57**	• Proposes new beneficiary and public notice requirements	individuals under 150% FPL and exempt individuals. • Technical clarification needed - §447.54(c) should refer to paragraph (b) not (a). • Simplifying the exemption of Native Americans from cost sharing provisions is greatly appreciated. • To the extent an ongoing process is needed to confirm this exemption status, state flexibility, in consultation with its applicable Tribal Leaders for local implementation is key. • One approach for periodic ongoing assessment of this exemption status would be to annually match, during the annual redetermination process, eligibility files containing certified Native Americans against claims data and to the extent this is not successful, the use of self attestation with paper verification from the individual at time of the annual redetermination period would be sought.

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Consumer Assistance	***45 CFR:* 155.225**	Would provide the standards on which an Exchange will certify application counselors to facilitate enrollment in the Exchange. Would also outline the standards for certification of individuals seeking to become application counselors. Would require the Exchange to establish procedures to withdraw certification from individual application counselors, or from all application counselors associated with a particular organization, when it finds noncompliance with the terms and conditions of the application counselor agreement. Would also require the Exchange to establish procedures to ensure that applicants are informed of the functions and responsibilities of certified application counselors, and provide authorization for the disclosure of applicant information to an application counselor prior to a counselor helping the applicant with submitting an application. Would prohibit certified application counselors from imposing any charge on applicants for application assistance.	• 155.225(a): The role of Certified Application Counselors is unclear in the proposed rule. If this category is intended as a framework to cover non-paid assisters, the rule itself should incorporate preamble language to clarify this. • 155.225(b): States should be permitted to add certification standards that are appropriate and specific to state concerns or outcomes.
Verification process related to eligibility for insurance affordability programs	**155.320(d)**	Would consolidate paragraphs (d) and (e), currently entitled "Verification related to enrollment in an eligible employer-sponsored plan" and "Verification related to eligibility for qualifying coverage in an eligible employer-sponsored plan," respectively, into new paragraph (d), entitled "Verifications related to enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer- sponsored plan." The new paragraph (d) would set forth the rules for verifying enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan, and proposes a process under which an Exchange may rely on HHS to complete this verification. Would specifically require the Exchange to verify whether an applicant reasonably expects to be enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested. Would add, under paragraph(d)(3) entitled "Verification procedures," that if the Exchange does not have any of the information specified in paragraph (d)(2) for an applicant or an applicant's attestation is not reasonably compatible with the specified information, the Exchange *must select a statistically significant random sample of such applicants* and must: (A) Provide notice to the applicant indicating that the Exchange will be contacting any employer identified on the application for the applicant and the members of his or her household to verify whether the applicant is enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested;	• There are no acceptable data sources that will be available in California by 10/1/2013. • California appreciates and is actively considering the federal option for verification of an eligible employer-sponsored plan.

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		(B) Proceed with all other elements of eligibility determination using the applicant's attestation, and provide eligibility for enrollment in a QHP to the extent that an applicant is otherwise qualified; (C) Ensure that APTC and CSR are provided on behalf of an applicant who is otherwise qualified for such payments and reductions, as described in §155.305, if the tax filer attests to the Exchange that he or she understands that any APTC paid on his or her behalf are subject to reconciliation; (D) Make reasonable attempts to contact any employer identified on the application for the applicant and the members of his or her household, as defined in 26 CFR 1.36B-1(d), to verify whether the applicant is enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested; (E) If the Exchange receives any information from an employer relevant to the applicant's enrollment in an eligible employer-sponsored plan or eligibility for qualifying coverage in an eligible employer-sponsored plan, the Exchange must determine the applicant's eligibility based on such information and in accordance with the effective dates specified in 155.330(f), and if such information changes his or her eligibility determination, notify the applicant and his or her employer or employers of such determination in accordance with the notice requirements specified in §155.310(g) and (h); and (F) If, after a period of 90 days from the date on which the notice described in paragraph (d)(3)(iii)(A) of this section is sent to the applicant, the Exchange is unable to obtain the necessary information from an employer, the Exchange must determine the applicant's eligibility based on his or her attestation regarding that employer. (G) In order to carry out the above verification procedures, the Exchange must only disclose an individual's information to an employer to the extent necessary for the employer to identify the employee. Finally, would provide the Exchange an option to rely on verification performed by HHS, provided that: (i) The Exchange sends the notices described in §155.310(g) and (h); (ii) Other activities required in connection with the verifications described in this paragraph are performed by the Exchange in accordance with the standards identified in this subpart or by HHS in accordance with the agreement described in subpart (iv) below; (iii) The Exchange provides all relevant application information to HHS through a secure, electronic interface, promptly and without undue delay; and (iv) The Exchange and HHS enter into an agreement specifying their respective responsibilities in connection with the verifications described in this paragraph.	
Special Enrollment	**155.420(d)**	Would amend paragraph (d) to specify that the Exchange must allow, when specified in the paragraphs therein, for a dependent of a qualified individual or enrollee to qualify for a special enrollment period, subject	California supports proposed provisions allowing dependents of qualified individuals/

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Periods		to whether the QHP that such individuals wish to select covers the dependents. This would accommodate situations in which all members of a household would likely need to enroll in or change QHPs in response to an event experienced by one member of the household, such as a dependent losing minimum essential coverage.	enrollees to qualify for a special enrollment period. We support the movement of related individuals for other special enrollment periods, where those individuals are affected by the eligibility of a qualified individual.
Termination of Coverage	**155.430**	Would divide paragraph (b)(1) into two paragraphs: (b)(1)(i), which replaces the existing (b)(1), and (b)(1)(ii), which would require the Exchange to provide an opportunity at the time of plan selection for an enrollee to choose to remain enrolled in a QHP if the Exchange identifies that he or she has become eligible for other minimum essential coverage through the periodic data matching and the enrollee does not request termination in accordance with paragraph (b)(1)(i) of this section. If an enrollee does not choose to remain enrolled in a QHP in such a situation, the Exchange must initiate termination of his or her coverage upon completion of the redetermination process specified in §155.330. Would amend paragraph (d)(1) to specify that changes in APTC and CSR, including terminations, must adhere to the effective dates specified in §155.330(f), which ensures alignment of processes.	California strongly recommends giving states the flexibility to present this choice to the individual at a time other than at plan selection if it is determined to be more convenient and/or understandable for the individual.
Appeals Coordination	**155.510**	Would require the appeals entity or the Exchange to enter into agreements with the agencies administering IAPs regarding the appeals processes for such programs as are necessary to fulfill the requirements of this subpart. The agreements must clearly outline the responsibilities of each entity to support the eligibility appeals process, and must: minimize burden on appellants, including not asking the appellant to provide duplicative information or documentation that he or she already provided to an agency administering an IAP or eligibility appeals process; ensure prompt issuance of appeal decisions consistent with timeliness standards established under this subpart; and comply with the coordination requirements established by Medicaid under 42 CFR 431.10(d). Would provide for coordination standards for Medicaid and CHIP appeals. Would provide that the appellant must be informed of the option to opt into pursuing his or her appeal of an adverse Medicaid or CHIP determination made by the Exchange directly with the Medicaid or CHIP agency, and if the appellant elects to do so, the appeals entity must transmit the eligibility determination and all information provided via secure electronic interface, promptly and without undue delay, to the Medicaid or CHIP agency, as applicable (it is assumed that most appellants would not opt into having their appeal heard by the Medicaid agency, which would result in two separate appeals, one before the Exchange appeals entity and one before the Medicaid or CHIP agency, and would instead choose to have both Medicaid or CHIP and Exchange-related issues heard before the Exchange appeal entity).	California understands the data exchange requirements in Section 155.510(c) and believes they constitute a reasonable goal. However, the state of automation of appeals processes is not sufficiently developed at this time to accommodate electronic interfaces. California therefore recommends a phased-in approach to establishing a secure electronic interface between the Exchange and other IAPs.

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		Would provide that if the Exchange appeals entity conducts the hearing on the Medicaid or CHIP denial, that hearing decision would be considered final, and the appeals entity may include in the appeals decision a determination of Medicaid and CHIP eligibility. However, the appeals entity must apply MAGI-based income standards and standards for citizenship and immigration status using verification rules and procedures consistent with Medicaid and CHIP requirements under 42 CFR parts 435 and 457. Would also provide that notices required in connection with an eligibility determination for Medicaid or CHIP must be performed by the appeals entity consistent with standards set forth by this subpart, subpart D, and by the state Medicaid or CHIP agency, consistent with applicable law. Would require the Exchange to consider an appellant determined or assessed by the appeals entity as not potentially eligible for Medicaid or CHIP as ineligible for Medicaid or CHIP based on the applicable Medicaid and CHIP MAGI-based income standards for the purposes of determining eligibility for APTC and CSR. Would finally require appeals entities to ensure that all data exchanges that are part of the appeals process comply with the requirements of §155.260, §155.270 and §155.345(h) and comply with all data sharing requests from HHS.	
Informal Resolution and Hearing Requirements and Appeals Decisions	**155.535** **155.545**	Would provide that the HHS appeals process will provide an opportunity for informal resolution and a hearing, and that a state-based Exchange appeals entity may also provide an informal resolution process prior to a hearing, provided that the process is limited in scope to what would be considered at hearing, including the information used to determine the appellant's eligibility as well as any additional relevant evidence provided by the appellant during the course of the appeal, and that the process will not impair the appellant's right to hearing, where the appellant remains dissatisfied with the outcome of the informal resolution process (this would parallel the Medicaid fair hearing requirement that an appellant must be provided a hearing where he or she believes the agency has taken an erroneous action). Such an informal resolution would provide appellants the opportunity to work with appeals staff to try to resolve the appeal pre-hearing through a review of case documents, verification of the accuracy of submitted documents, and the opportunity for the appellant to submit updated information or provide further explanation of previously submitted documents. Would require the appeals entity to issue written notice of the appeal decision to the appellant within 90 days of the date an appeal request is received, as administratively feasible. In case of an expedited appeal, the appeals entity must issue notice of the appeal decision as expeditiously as the appellant's health condition requires, but no later than three working days after the appeals entity receives the request	In the preamble to this proposed rule, HHS states that an informal resolution process at the Exchange could resolve a number of appeals without the need for a fair hearing. California strongly agrees with this assessment. However, the 90-day appeal period does not provide sufficient time to conduct a comprehensive informal process while ensuring the appellant's right to a formal hearing. Based upon California experience in the CHIP program, we know that a minimum of 60 days is necessary to conduct an adequate informal appeal process. Therefore, California recommends that in **155.545(b)(1)** states be given a total of 120 days from the date of the appeal

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		for an expedited appeal.	request, rather than 90 days, to issue the final formal decision.
Employer Appeals Process	**155.555**	Would require that an appeals process be established through which an employer may appeal, in response to a notice under §155.310(h) regarding an employer's potential tax liability, a determination that the employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide such coverage but it is not affordable coverage with respect to the employee referenced in the notice. The employer appeal is the opportunity for the employer to correct any information the Exchange received from an employee's application regarding the employer's offering of coverage. The appeals entity is responsible for a de novo review of whether the employer's offer of coverage is sufficient such that the employee at issue is not entitled to APTC or CSR. This employer appeals process is separate and distinct from the IRS's process determining whether an employer is liable for a tax penalty under section 4980H of the Code and any appeal rights the employer may have under subtitle F of the Code. Would provide the Exchange with the flexibility and option to establish an employer appeals process in accordance with the requirements of sections 155.505(e) through (g), and 155.510(a)(1), (a)(2), and (c), but where an Exchange has not established an employer appeals process, HHS will provide an employer appeals process that meets the requirements of this section.	• California appreciates and is actively considering the option of requiring California employers to appeal directly to HHS. • California requests clarification about how and in what timeframe HHS will relay appeals information back to states that choose this option.

CMS-2334-P: Proposed Rule on ACA Medicaid Changes: Benefits and Eligibility

Alternative Benefit Plans and Essential Health Benefits (EHB)

Secretary-approved coverage and EHB Referencing (42 CFR §440.330(d) and §440.347(b)): States electing to provide state plan mirroring benefits under the Secretary-approved option should not be required to supplement with additional EHB services.

For states electing state plan benefits under the Secretary-approved option, the proposed process for EHB referencing remains problematic and presents inconsistency with ACA intent. The optional expansion of Medicaid to previously unlinked individuals essentially marks a new program when compared to pre-ACA Medicaid, which served only the most categorically vulnerable. Reflecting this, the benefit component of expansion is designed to contain costs (i.e., requiring the new adult group to receive coverage under Sec. 1937) and more closely align with the trend in the private insurance market (i.e., application of EHB to Sec. 1937). The EHB standard is only made applicable to Medicaid in the context of Sec. 1937, and at this time for California, this will only implicate the new adult population. Despite this design, there are certain categories of benefits (such as substance use disorder services) that could be made more generous through referencing for the relatively less vulnerable, higher income expansion group as compared to existing Medicaid beneficiaries (and those exempted from mandatory benchmark enrollment). Additionally for states that do not provide or have eliminated certain optional benefits under their Medicaid programs, the EHB standard and referencing may further expand benefits for the higher expansion group in comparison to existing Medicaid beneficiaries which can further add to disparities in benefit packages for the applicable populations. Looking at the legislative choice for more cost effective and commercial-like coverage, Congress certainly could not have intended for new enrollees to end up receiving more robust coverage than the categorically needy population base.

Additionally, incoming beneficiaries who may be disabled or not entirely sure of their future benefit needs at the point of application will be choosing between disparate benefit schedules, along with the administrative complexity for states in noticing and ensuring proper placement. The only way to mitigate this and achieve alignment would be to expand all benefits for both existing and newly eligible beneficiaries, something that states facing other mandatory programmatic expansions are not in the fiscal position to do. Again, the ACA does not evince congressional intent for a program-wide benefit expansion or departure from longstanding state discretion under title XIX to design appropriately balanced benefits. If states must expand all benefits for both existing and newly eligible beneficiaries then states must be able to receive 100 percent federal financial participation for these benefits.

The proposed EHB referencing process is too onerous, given the time and resource constraints faced in ACA implementation by both states and the federal government, and the lack of meaningful specifics needed to complete the process. Further, while the statute requires that Sec. 1937 coverage include the EHB categories enumerated under ACA Sec. 1302(b), it does not mandate importation of entire segments of coverage from private plans nor does it require a wholesale matching of these offerings in Medicaid on a service-by-service basis.

This may produce impediments to benefit alignment and conflicting results, one example being in the context of the Sec. 1905(a)(29)(B) restriction on receipt of federal financial participation (FFP) for services to adults under 65 years of age in Institutions for Mental Disease. If the current approach to referencing is retained, states will require guidance on any required provision of, and the availability of FFP for, services not germane to traditional Medicaid benefits. California requests that any supplementation of Sec. 1937 coverage necessary to ensure statutory EHB compliance is accomplished on a broader and more categorical scale, consistent with the existing confines of title XIX and traditional state discretion in benefit and delivery design.

Provision of Long Term Care and Exempt Individuals (42 CFR §440.315): States should be able to employ traditional Medicaid disability assessments in evaluating the medically frail exemption, and limit receipt of long term care services and supports to those undergoing asset testing.

To ensure long term program stability and a fiscally sound expansion, California requests sufficient flexibility to limit receipt of non-EHB services (including LTCS) to the non-expansion population via state plan amendment or Sec. 1915(c) waiver. Access to the services not contemplated for the expansion population by Congress must continue to be subject to asset testing. We recommend revision to the medically frail exemption to align with the disability assessments already in use within Medicaid.

The proposed revision to an already expansive definition for the medically frail exemption to mandatory benchmark enrollment seems to run against the ACA's benefit design for the expansion population, i.e. coverage tied to Sec. 1937 and incorporation of an EHB standard from the individual and small group markets which excludes coverage for long-term care services and supports (LTCS). ACA congressional goals to contain the costs of the Medicaid expansion may be jeopardized if states are faced with widespread eligibility for LTCS without the traditional program integrity tools used to filter such services based on objective need.

Existing DRA benchmark rules already exempt a broad range of relative vulnerability as compared to a traditional disability assessment, including those with one or more significantly impaired activities of daily living. Within what is likely to be a large exempted class, these

beneficiaries will access benefits otherwise excluded from the EHB standard, namely institutional or home/community-based LTCS through the state plan at sizable cost to states and the federal government alike. Of particular concern is the application of the Personal Care Services benefit (in California, In Home Supportive Services) to a large exempt segment of the new adult group, even in recognition of the enhanced federal funding available for the newly eligible. In addition, such non-EHB services would be accessed in the streamlined, MAGI enrollment environment where asset evaluation would be prohibited.

Mental Health and Substance Use Disorder Parity (42 CFR §440.345(c)): Medicaid regulations should expressly clarify that states may employ the same mental health and substance use disorder carve-outs for the expansion population as used for existing populations and remain in compliance with federal parity laws.

California remains committed to integration and coordination of mental health and substance use disorder (MHSUD) benefits with medical and surgical benefits, alongside our ability to tailor the delivery of all Medicaid services to the unique needs of our population and programs. In the midst of a dramatic eligibility expansion and modernization of enrollment processes, continuity and alignment of other programmatic features must be maximized. To these ends, we aim to integrate the expansion population into existing carve-out or waiver arrangements. As discussed with respect to the EHB referencing process, states should not be required to provide different or additional MHSUD benefits to the expansion population than what is furnished to existing beneficiaries.

As noted in the January 16, 2013 State Medicaid Directors Letter on parity, we request prompt release of additional guidance concerning any requirements to apply parity principles across multiple managed care delivery systems. We urge a flexible approach to measuring parity in carve-out settings in promotion of continuity for existing arrangements and authorities.

Additional benefits-related points:

- *Exempt individuals and receipt of enhanced federal funding* (42 CFR §440.305(b) and §440.315): We request formal clarification that enhanced FMAP is available for newly eligible individuals that are exempted from mandatory benchmark enrollment under Sec. 1937.

- *Exempt individuals, medically frail, and substance use disorders* (42 CFR §440.315(f) and 78 FR 4594, 4631): California recommends that the medically frail exemption be based only upon evaluation under traditional Medicaid disability assessments.

- *Exempt Individuals and single streamlined application environment* (42 CFR §440.315): We request additional guidance regarding any informational or timeliness requirements in identifying benchmark-exempt individuals through the single streamlined application and the process for allowing those exempt to opt-out of Sec. 1937 coverage.

- *Habilitative services* (42 CFR §440.347(a)(7), (d), and 78 FR 4594, 4630): California supports the approach allowing for a state-defined and Medicaid-specific benefit separate from the approach used for the individual and small group markets.

- *EHB reference options and targeting* (42 CFR §440.347(c)): We request the ability to select EHB categories from amongst multiple EHB benchmark reference plans for inclusion into a single alternative benefit plan (ABP) for a particular population, in addition to the proposed ability to select a different EHB benchmark reference plan for each ABP.

- *Nondiscrimination in benchmark* (42 CFR §440.347(e) and 78 FR 4594, 4630): The nondiscrimination language in this subsection appears overly broad and not consistent with the purpose behind the alternative benefit flexibility of Sec. 1937. The regulatory language should express the preamble policy from p. 4630: "Benefit design nondiscrimination policies do not prevent states from exercising Section 1937 targeting criteria."

- *Additional Services* (42 CFR §440.360): We request clarification that the election of state plan benefits under the secretary-approved option is considered to be "benchmark coverage," so as to not implicate the restriction on additional coverage for the new adult group contained in this section.

Eligibility and Cost Sharing

General: California requests that federal model agreements on Medicaid-Exchange coordination (pursuant to 42 CFR §435.1200) be made available to states as soon as possible.

MAGI application to family planning state plan option (42 CFR §435.214):

Under ACA §2303(a)(2) (42 USC §1396a(ii)(2)), states opting to convert Section 1115 family planning waivers to a state plan option program are authorized to include individuals who, had they applied, would have been made eligible pursuant to the standards and processes imposed as of January 1, 2007. California and its relevant stakeholders relied on this option to retain unique eligibility features of the predecessor Family PACT waiver in conversion, including a simplified, standalone provider-based application and enrollment process. While the preamble

identifies the notwithstanding clause of the MAGI provision (42 USC §1396(e)(14)(D)) in explaining why MAGI methodologies must apply to this eligibility group, it goes on to allow for deviation from this standard to accommodate another ACA family planning eligibility option at 42 USC §1396a(ii)(3) (consideration of only the income of the applicant). Statutory and regulatory consistency should require a similar approach to allow for concurrent operation of the ACA's waiver-grandfathering provision. We urge CMS not to require the application of, or conversion to, MAGI for states that exercised the (ii)(2) authority, in recognition of the significant disruption and complication this would bring to the current program.

Medically Needy (42 CFR §435.310):

California would again ask for federal guidance relating to the treatment of the Medically Needy (MN) program. Under the MN program, beneficiaries often have a spend down/share of cost (SOC) requirement. Under Medicaid rules, a person is not eligible until they have met their SOC. Given the fact that this is an optional coverage category for states and the applicable spend down requirements for certain individuals within this coverage category, it is desirable for states to have flexibility in the treatment of MN individuals in this new world of eligibility simplifications. Specifically flexibility is requested for maintaining MN program services for aged or disabled populations while eliminating the MN program for parent/caretaker relatives and pregnant women who are eligible for Exchange coverage. The MN program is no longer needed for this population receiving Exchange coverage especially since they will otherwise not be certified as having Medicaid coverage to the extent they have not met their applicable SOC. To the extent they do not meet their SOC, it is unknown the extent to which this will have impacts on determining if they meet minimal essential coverage or not. Lastly, enrollment via the Exchange with premium tax credit subsidies will help to ensure their primary care needs are met via the participating qualified health plans.

Premium assistance and pregnancy-related only coverage (42 CFR §1015)

The proposed IRS rule for minimum essential coverage at 26 CFR §1.5000A-2(b)(2)(iii) excludes Medicaid coverage of pregnancy-related services from the definition of government sponsored program. Looking at a scenario of a woman enrollee in a qualified health plan receiving advanced premium tax credits (APTCs) who becomes pregnant and whose income is within the eligibility standard for pregnancy-related only coverage in Medicaid (if a state elected to exercise this option), this enrollee would seemingly remain eligible for APTCs. However, the premium assistance treatment in the preamble states that "APTC would not be provided for the Medicaid or CHIP-eligible family members" (78 FR 4594, 4624). We request guidance on how premium assistance would work in this scenario of pregnancy-related coverage, and more generally, how state Medicaid agencies are expected to treat such an instance of concurrent IAP eligibility.

Presumptive eligibility determined by hospitals (42 CFR §435.1110):

The proposal for hospital determined presumptive eligibility (PE) is an area of concern given its divergence from the foundational Medicaid principle of a single-state-agency serving as the central source for programmatic choices. State Medicaid agencies should not be in the position of providing oversight of PE determinations for coverage groups for which the state plan does not offer PE (and for which no policies or procedures specific to that coverage group would exist). We understand that the proposal is dictated to an extent by the statutory wording of ACA §2202, but implore CMS to equip states with the maximum amount of flexibility, oversight capacity, and enforcement certainty that can be extended under a reasonable interpretation of the provision.

We request that CMS provide regulatory clarification around enforcement which specifies the allowable types and extent of sanctions that can be employed (fiscal or otherwise), and the threshold(s) and process states may use in disqualifying noncompliant hospital participants. It is important for states to be able to secure express federal approval of these chosen standards in building a workable model for oversight, preferably through a state plan amendment.

California supports the state option to require a participating hospital seeking qualified entity status to assist individuals in completing and submitting the full application, and with the understanding any documentation requirements. This will not only help to prevent instances of recurring PE use, but will also align with the performance measures tracking the number of applications submitted within the PE period and the number of successful/accurate determinations of full eligibility. We request additional guidance concerning the federal support (financial and/or technical assistance) available to integrate hospital participants into states' modernized application and enrollment environments.

California also requests that PE period cases that never complete an application for Medicaid are treated as newly eligible individuals. States will not have sufficient information to determine whether these individuals would have been eligible under the rules prior to 2009. Therefore, states should receive 100 percent federal financial participation for these cases.

Cost sharing enforceability (42 CFR §447.51(d))

California supports the streamlining and simplification of existing cost sharing rules, but the practical value of such flexibilities remains limited when payment enforceability is overly restricted under the state plan or waiver. We recommend that the regulatory language be amended to mirror 42 USC 1396o-1(d)(2) by removing the 100% FPL or above limitation on enforceability. This statutory provision allows states to permit participating providers to require payment of any authorized cost sharing as a condition of provision of care, without restriction based on income level and without regard to any other provision of law. Under

either a state plan or waiver cost sharing arrangement, we note that instances of financial hardship may be mitigated by the case-by-case availability for providers to waive or reduce the application of cost sharing.